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ABSTRACT

Over the past two decades, the chronic mentally ill elderly have begun to receive care in residential health care facilities (RHCF) such as domiciliary care, intermediate care, and skilled nursing facilities. While there is justification for this increase, as the mentally ill elderly also present with significant physical illnesses, there are presently more chronic mentally ill elderly residents of RHCFs than of state mental hospitals. The need to provide care to the mentally ill in the RHCF is expanding. Not only are patients admitted with a primary diagnosis of mental illness, many are admitted with unreported mental illnesses and others develop illnesses while institutionalized. Related key issues include accurately defining patient needs so as to respond appropriately, and addressing the patient's desire to be placed homogeneously by type of need. Several recent reports indicate the efficacy of behavioral intervention programs for the chronic mentally ill in RHCFs. This paper reviews those reports and a report on the preliminary findings of the impact of a staff psychologist on the provision of mental health services in eight RHCFs. (Author)

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RESIDENTIAL HEALTH CARE FOR THE CHRONIC MENTALLY ILL

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ABSTRACT

Over the past two decades many chronic mentally ill elderly have increasingly begun to receive care in residential health care facilities (RHCF) including domiciliary care, intermediate care and skilled nursing facilities. While there is justification for this increase, as the mentally ill elderly also present with significant physical illnesses, there are presently more chronic mentally ill elderly residents of RHCF's than of state mental hospitals. Furthermore, the need to provide care to the mentally ill in the RHCF is expanding. Not only are patients admitted with a primary diagnosis of mental illness, many are admitted with unreported mental illnesses and others develop illnesses while institutionalized. Related key issues include accurately defining patient need so as to respond appropriately, and patients desire to be placed homogeneously by their type of need.

Several recent reports indicate the efficacy of behavioral intervention programs for the chronic mentally ill in RHCF's. This paper will review them as well as report on the preliminary findings of the impact of a staff psychologist on the provision of mental health services in eight RHCF's.

RESIDENTIAL HEALTH CARE FOR THE CHRONIC MENTALLY ILL

Large number of both physically and mentally impaired older adults have historically been cared for in public state mental hospitals. These individuals were either long-term patients who grew old in these institutions or were placed later in life because of their illnesses (George, 1984). This historical trend has begun to change over the past two to three decades. Prior to the development of skilled nursing facilities as we know them, public mental hospitals provided the only available institutional setting for the aged who needed this type care. With the advent of Medicare and Medicaid and the concomitant expansion of institutionalized skilled nursing services for the elderly, an alternative for care was established, the residential health care facility (RHCF).

Originally the RHCF was designed exclusively as a health facility to tend for the ill, often indigent, elderly. It has, however, expanded in scope and now, as we will see shortly, includes a broader range of services offered to a population somewhat different from that originally planned for.

The rush to deinstitutionalize public mental hospitals in the late 1960's and early 1970's led to the transfer of many chronic mentally ill elderly from public mental hospitals to other health and social care settings (Lerman, 1981). Recent data, for example, from the New York State Office of Mental Health suggests that the average adult daily census in New York State mental hospitals dropped from a high of over 90,000 in 1955 to about 20,000 today (New York Times, September, 1987). A similar decrease can be noted nationwide; the number of elderly patients admitted to State mental hospitals dropped 79 percent between 1965 and 1979 (Taube & Barrett, 1983). While the rate of usage has dropped in these settings, the need for services remains high. A parallel increase of 306 percent was noted for the years 1955 to 1977 in the total number of patient care episodes in all mental health facilities - from 1.6 million to 6.9 million (NIMH, 1980). Clearly the need is great, yet the traditional State mental hospital setting is no longer the primary institution for the provision of this care.

Currently, older adults receive their institutional health care in residential health care facilities (RHCF). RHCF's consist of intermediate care facilities (ICF) or health related facilities (HRF), and skilled nursing facilities (SNF) (Salamon, 1986). While not in the same precise category, residential care facilities which include domiciliary care facilities or adult board and care homes are often combined in with this same schematic. The reason is that many of the residents of these facilities suffer from a chronic mental illness as well.

It has been repeatedly established that an important characteristic of the aged mentally ill is that they also present with significant physical illness (Kay, Beamish & Roth, 1964; Lowenthal & Berkman, 1967; Sakauye, 1986). Thus an important issue of providing care for both physical and mental illness simultaneously exists. Perhaps it is, therefore, not unrealistic to find that at present there are more mentally ill elderly residents of nursing homes and RHCF's in general than of State mental hospitals (Liptzin, 1984; Liptzin, 1985). Extrapolating data from the 1977 NCHS survey of nursing homes which is now over a decade old and certainly a conservative figure (NCHS, 1979) 20.4 percent of the residents of long term health care facilities had a primary diagnosis of a mental disorder. These diagnoses included senile psychoses, other psychoses, dementia, mental

retardation and alcoholism. All of these diagnoses are chronic, in the sense that there is no cure and half of them are indicative of a long-term problem, having begun much earlier in life. Indeed there is clear indication that approximately 800,000 psychiatric episodes occurred in nursing homes in 1982. This is particularly interesting as the Federal guidelines for Medicaid, Institution for Mental Disease (IMD) guidelines, promulgate what has been referred to as the "50% rule". Under this rule a facility can lose its Medicaid funding if more than half of its residents have mental disorders.

The national data base on psychiatric hospitalization is sparse. There is evidence, however, as suggested above, that in spite of the deinstitutionalization movement, the overall rate of mental hospital admissions continues to rise (Kiesler, et. al. 1983). Admissions rise but because of deinstitutionalization, patients are very rapidly discharged. With this increase of rates of admission and discharge comes evidence of increasing rates of institutionalization for mental illness in RHCF's. Not only are the chronic mentally ill receiving care in skilled nursing facilities, but as many as 60-70 percent of the residents of domiciliary care and intermediate care facilities have a

diagnosis of chronic mental illness (Dittmar & Franklin, 1980a, 1980b; Schmidt, et. al., 1977; Shadish, et. al., 1981). This is significantly above the 20 percent rate found in the National Nursing Home Survey.

In a rather informal survey of the several RHCF's, I am involved in, I have found that an interesting phenomenon exists. One or two of the units in these facilities generally have alert and oriented patients with few mental health problems. The greater proportion of units, however, tend to have an overwhelming majority of patients with either a primary or secondary diagnosis of chronic mental illness. In four facilities where a review of all the patients charts was performed, the findings indicated that the overall percent of patients with a primary or secondary psychiatric diagnosis ranged from 53 to as high as 88. So much for the 50% rule. Furthermore, a review of the discharge rate from acute care hospital psychiatric units to RHCF's for the catchment area in which I am employed indicated that on average 25% of all geriatric psychiatry patients are discharged from hospital to a RHCF. Many of these patients in the past would have been transferred to State mental hospitals not domiciliary care facilities, ICF's or nursing homes.

To the degree that an awareness existed that patients with psychiatric needs were being transferred to RHCF's the Department of Health Education and Welfare in 1977 issued specific guidelines on what was acceptable methods of handling these patients' behaviors in these settings (HCFA memo, May 11, 1977). Specifically the report stated:

> "Staff must be particularly alert to giving supportive care to patients on psychotropic medications as the use of medication alone is generally not sufficient... An acceptable principle of patient care is the staff's establishment of trusting relationships... Such relationships are preferable to physical and chemical restraints." (5-81-40).

Despite these guidelines it is a well established fact that the staff of RHCF's are not well trained to handle patients with psychiatric ailments and find it more expeditious to apply chemical control, in the form of psychotropic medications, than the establishment of a "trusting relationship".

Recently a coalition of 50 professional organizations lobbying for nursing home reform met to make recommendations to Federal legislators (DeAngelis, 1987). Included among the suggestions they made were to modify the 50% rule and not threaten to penalize RHCF's that serve patients with mental illnesses. Additional recommendations included to amend the Social Security Act to require RHCF's to make specific mental health services available to the patients of these facilities and to implement a reimbursement mechanism to cover mental health services needed by nursing home residents. At this point the mental health services that are available are limited to a very part-time psychiatric consultant and a social service worker who spends most of the work week dealing with concrete issues.

In one case study (Sherman & Salamon, In press) of a patient with a diagnosis of schizophrenia admitted to a nursing home from an acute care hospital, it was found that over the course of the 18 months the patient was at the SNF there were a total of 15 psychiatric consultations performed with just as many changes in psychotropic medications suggested in the patient's chart. A behavioral intervention program, begun to help control the patient's negative behaviors, was sabotaged by staff who felt that the patient was perpetually "on his way out" to a State psychiatric hospital. They, therefore, did not take part in nor follow through with the recommended program. Ultimately the

patient was indeed transferred to a psychiatric facility. Interestingly, the patient was discharged from the State mental hospital about two months later and transferred back to a different nursing home. And thus the cycle continues.

In sum, there is a clear need for providing care for the chronic mentally ill elderly in RHCF's. The intent of this paper is not to argue for or against institutional treatment for the mentally ill elderly in psychiatric facilities, but rather to recognize that a need for intervention presently exists in settings other than State hospitals and must be definitively addressed. Within RHCF's there exists a very large population of older adults with a primary diagnosis of a chronic mental illness. The need to provide care for this population is further exacerbated by the fact that many other individuals in these facilities often have secondary diagnoses of mental illness that go unreported, and a further group of individuals exists who develop a mental illness subsequent to their institutionalization.

The concept of a continuum of long-term care by which policy makers elaborate the needs of the elderly confuses the issue of defining specific patient need (i.e., physical versus mental) and thereby adds to the need by beauracratically misunderstanding the imperative for care as we see, for example, in the somewhat arbitrary 50% rule. An additional variable to factor in is that patients themselves appear to prefer homogeneous placement by type of need in nursing homes (Salamon, 1983). The patients themselves have needs that they are aware of that require an awareness of the environment in which they live. It is difficult for patients whose behavior is social, aware, alert and simply put, normal and acceptable to be forced to live with others whose disorders make them behaviorally unstable. In a survey of 22,897 residents of domiciliary care facilities it was found that the overall rate of social participation of chronic mentally ill in facility programs is low (Sherman & Snider, 1981). In a similar study it was found that recreation and socialization programs in which both chronic mentally ill and frail older adults were both invited to participate may have led to an overall lowering of the rate of interaction than when the two groups were involved in separate programs (Salamon & Nichol, 1980). In fact, the desire for homogeneous placement seems to work both ways.

It is quite possible that the situations and setting of programs may have an important impact, but in RHCF's originally designed for patients whose mental health needs were less profound, it is the responsibility of the care providers to vigorously attempt to treat, improve, in general have a positively controlling impact on the behavior of patients who just 20 years ago would have never found their way into these environments.

There are several ways of controlling the behavior of patients who suffer a chronic mental illness. The most common form is through the use of psychotropic medications. While medications clearly have their place, the concept of patients with paranoid eyes staring out from behind the haze of a major tranquilizer is antithetical to not only the gist of the DHEW memo of May 1977 but against the law in several states. Nevertheless, at least one study found this to be the case (Schmidt, Reinhardt, & Kane, 1977). In this study the authors reviewed the records of 1,155 patients in nursing homes in Utah. What they concluded was that about 20 percent of these individuals had come from State psychiatric hospitals and were diagnosed as psychotic. They also found that most patients received more medication the longer their stay in the facility. This led the authors to speculate that medication was being used to make the patients more compliant and docile.

Some States have nursing home legislation that makes it illegal to apply any major restraint, including chemical, that may cause the patient to lose control over his or her own free will. Furthermore, given the deteriorated physical condition of patients admitted to RHCF's, and it is important not to forget that the major admission requirement is still a chronic physical illness, many psychotropics are contraindicated as they can exacerbate the patients ailments. Thus while the first choice for intervention is often chemical, the second is usually behavioral.

Several recent reports indicate the efficacy of behavioral intervention programs for the chronic mentally ill in RHCF's (Brink, 1987; Dye, 1986; Goddard & Carstensen, 1986). It is important to interject that, as Dye (1986) has indicated the application of behavior therapy in nursing homes implies not just classic behavior modification but cognitive, social learning, modeling, biofeedback and related therapies as well. Not only do patients in RHCF's present with the traditional affective disorders including depression and anxiety and dementias, but they also present with eating disorders (Barry & Salamon, 1987) marital problems (Schlesinger & Salamon, In press) pain and hypochondrical behaviors (Kohl, McNeese, & Kaven, 1986) and as we are increasingly seeing, the psychoses.

Most reports of behavioral interventions with this population in the nursing home setting indicate their efficacy. Many of these clinical vignettes present specific guidelines for therapeutic intervention using an appropriate theoretical orientation and paradigm; patients are reinforced to overcome their depression by increasing socialization through modeling and successive approximations, inappropriate sexual acting out is controlled by using time-out procedures, pain through relaxation techniques and biofeedback, verbal abuse and physical aggressiveness by finding appropriate outlets for their expression and positively reinforcing the behavior in only these settings and so forth. However, as reported before, if staff does not view the patient as appropriate to the facility the likelihood of success of any program is greatly diminished. Therefore, staff in RHCF's must be better prepared to provide a consistent, therapeutic milieu for their patients with chronic mental illness.

I am a firm believer in learning by doing and sharing experiences once they are understood. Thus some of the examples for interventions cited above are based on my own experiences having worked in the field for several years, and those of students I act as a preceptor for. The students in this program, all ABD or Ph.D. level psychologists are enrolled in an externship program in geriatric psychology. They are placed at a

SNF, ICF or Domiciliary Care Facility and act as the provider of direct psychological services. Patients are referred to them by other clinical care providers including physicians, nurses and social workers. The success of this program is dependent on several key factors, not least of which is financing. As you are all well aware, Medicare and Medicaid funding for psychological services is pitifully small. This program, however, is funded through a Community Mental Health Center which has a higher negotiated rate for reimbursement than an individual provider. Through the mechanations of the staff of the CMHC and governmental agencies, the staff patient contact which takes place at the RHCF is considered a "home visit" from the CMHC and is, therefore, reimbursed at the higher CMHC rate. While this adds to the paper work it seems a small price to pay to encourage the expansion of mental health services to this rather needy population.

Another key factor in the success of this program is the dedication of the individuals involved in providing care. A review of all the cases for the past two years indicates that 90 percent of the patients referred to the staff psychologist were referred because they had significant behavioral problems. Very few minor adjustment disorders with depressed moods here. These patients were aggressive, abusive, delusional or suffering major depressions and anxiety disorders. If they are not technically

diagnosed psychotic some certainly have major personality disorders which make them seem eccentric, behaviorally erratic or fearful. While it is difficult in any setting to measure change and improvement of patients receiving therapy we have established a rating system consisting of concrete goals and objectives on which each patient is ranked. All the rankings are Likert type and go from one to ten. We are not always successful in significantly changing the behaviors we set out to. Many are intractable. However, many patients do improve as measured by the psychologists ranking as well as by, in some cases, reducing the use of psychotropics, or suggesting more appropriate drugs or dosages, as well as by staff report of patient compliance with care and by family report of increased behavioral stability.

One of the reasons I believe the program is so successful is that all psychologists must have frequent contact with the regular care providers. This contact includes providing a minimum of four major inservices per year, discussing each case at a staff conference once every two months and allowing some staff contact in which consistent methods of behavioral intervention for a specified patient's problem is discussed to be counted as a portion of the therapeutic intervention time.

Still, the psychologist is just a consultant and it is the staff that must provide the majority of the care. In most cases

staff are simply unprepared to work with this population. I often hear comments from nurses in RHCF'such as "I didn't like psych. nursing before and I don't like it now." There is no simple way to address this issue. Some tend to believe that is is more a matter of burnout than discontent. Working with behaviorally disturbed elderly 40 hours a week can burn one out. Yet, this is the direction in which care is heading in RHCF's. Staff must be prepared for it. Cherniss (1987) has suggested several ways of handling this type of burnout, including individual counseling, social support groups and organizational development courses all of which have a positive impact on staff. But, individuals must become available who can provide this training.

In conclusion, while the phenomenon of chronic mental illness in RHCF's is relatively new, there is a great need for the provision of mental health care services to the residents of these facilities. Model programs exist which help set examples for the types of interventions needed in these settings. The State mental hospital is no longer the primary site for care of the geriatric patient with mental illness. We must seek to find the appropriate staff and balance of services for these patients in RHCF's as the setting is now a given.

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